Add, Change and Termination Form

It is recommended that this form be used to report any additions, changes and/or terminations to a provider's network affiliates.
If this form is being used, a separate form must be completed for each contracted provider being terminated or whose status is changing.

Health Network Name:

Program (Check all that apply): ☐ **Medi-Cal** ☐ **OneCare** ☐ **PACE**

PROVIDER INFORMATION

PROVIDER STATE LICENSE #		PROVIDER TIN #	
TYPE 1 NPI (National Provider ID #)	PROVIDER ID	MEDICARE #	MEDI-CAL EFFECTIVE DATE
PROVIDER NAME (Last)	(First)	(Middle Initial)	
PRIMARY TAXONOMY	SECONDARY TAXONOMY	TERTIARY TAXONOMY	ORDERING, REFERRING, PRESCRIBING (ORP) ☐ YES ☐ NO
AREA OF FOCUS	PRIMARY SPECIALTY	SECONDARY SPECIALTY	
GROUP NAME	PROVIDER TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
GROUP/TYPE 2 NPI (National Provider ID #)	GROUP ID	GROUP TIN	
SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)		CITY	STATE / ZIP
REMIT ADDRESS		CITY	STATE / ZIP
OFFICE MANAGER	PHONE	FAX	PUBLIC EMAIL ADDRESS
ADMINISTRATION EMAIL ADDRESS	WEBSITE URL ADDRESS	SPECIAL SERVICES ☐ CCS ☐ CPSP	

HOSPITAL/FACILITY AFFILIATIONS AND ADMITTING PRIVILEGES		
1. _____	2. _____	3. _____
☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF
☐ HONORARY ☐ CONSULTANT	☐ HONORARY ☐ CONSULTANT	☐ HONORARY ☐ CONSULTANT
☐ COURTESY ☐ LIMITED ☐ PROVISIONAL	☐ COURTESY ☐ LIMITED ☐ PROVISIONAL	☐ COURTESY ☐ LIMITED ☐ PROVISIONAL
☐ SENIOR ATTENDING ☐ SURGICAL	☐ SENIOR ATTENDING ☐ SURGICAL	☐ SENIOR ATTENDING ☐ SURGICAL
☐ SUSPENDED	☐ SUSPENDED	☐ SUSPENDED

☐ EMAIL ATTESTATION ON FILE

ACTION REQUIRED (Check all that apply)

☐ NEW ADD OR AFFILIATION

REQUIREMENTS: The Provider Relations (PR) representative must complete this form, including **credentialing information**, for each provider being added as a provider affiliate. In addition, **a copy of the recitation and signature pages from the provider contract and a W-9 form** must be attached. If copies are not attached, the form will be rejected by Provider Data Management Services (PDMS) and returned to the PR representative.

Effective Date **(required)**:	Date Credentialing Completed (within the last three years)	Current Facility Site Review Date (within the last three years)
PROVIDER TYPE	☐ **ANCILLARY/ALLIED HEALTH** ☐ **PCP** ☐ **SPECIALIST** ☐ **ECM** ☐ **COMMUNITY SUPPORTS**	☐ **Open Panel** ☐ **Closed Panel** ☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting new patients through referral ☐ Accepting new patients through a hospital/facility ☐ Not accepting new patients

☐ CHANGE IN PANEL STATUS

REQUIREMENTS: Panel changes are effective the date of processing.

PROVIDER TYPE (If applicable, check both)	
☐ **PCP** ☐ **SPECIALIST** ☐ **ECM** ☐ **COMMUNITY SUPPORTS**	☐ **Open Panel** ☐ **Closed Panel** ☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting new patients through referral ☐ Accepting new patients through a hospital/facility ☐ Not accepting new patients

☐ TAX ID CHANGE

REQUIREMENTS: The health network must attach a copy of the provider notification indicating the change of tax ID AND a new W-9 form.

Effective Date of New Tax ID (required):	Previous Tax ID	New Tax ID

^Optional to answer and not required

ACTION REQUIREMENTS (cont.) (Check all that apply)

☐ TERMINATION

REQUIREMENTS: Complete this form for each provider being terminated from its provider network affiliates. If the termination is requested by the provider, a copy of the request from the provider must be attached. If a copy is not attached, the form will be rejected by PDMS and returned to the PR representative.

Effective date (required):	☐ PCP ☐ SPECIALIST ☐ ANCILLARY

Date CalOptima Health received the termination notice:

Exceptions: Review found that the termed specialist is exempt from providing continued access based on the exemption checked below.

- ☐ Provider not available
- ☐ Provider retired
- ☐ Contract not continued
- ☐ Other: _____
- ☐ Provider deceased
- ☐ Provider unwilling to accept member/payment terms
- ☐ Termed due to review action

PCP Termination: Assign member to new PCP: _____
Name of new PCP

Number of members impacted (as of date received): ☐ **Medi-Cal** _____ ☐ **OneCare** _____

Date member notice was mailed (if member notice has not been sent, please put anticipated date and notify CalOptima Health if date changes):

Number of days' notice provider gave to MCP:

☐ ADDRESS/PHONE CHANGE OR ADDITIONAL LOCATION

REQUIREMENTS: For all address changes, select [TERM] to remove an old/prior address and select [ADD] to add the new location. For additional location, select [ADD] to add the additional location. If PCP site, a facility site review is required. A copy of documentation submitted by the provider AND a new W-9 form must be attached, if applicable. Note: The form contains three address sections, allowing multiple changes to be entered for one provider on the same form.

SERVICE ADDRESS **Check one: [ ] ADD [ ] TERM**	Effective Date (required):	SITE TELEHEATH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-Person	
Address		City	State / ZIP
Phone	Fax	Office Hours	After Hours Phone
Office Manager		Email Address	

SERVICE ADDRESS **Check one: [ ] ADD [ ] TERM**	Effective Date (required):	SITE TELEHEATH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person	
Address		City	State / Zip
Phone Number	Fax Number	Office Hours	After Hours Phone Number
Office Manager		Email Address	

☐ LANGUAGE

Languages Spoken by Staff

1. _____ 2. _____ 3. _____

Languages spoken by provider, if fluent with communicating about medical care, put an asterisk next to the language (^ Language fluency is optional to disclose and not required)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Language services, such as American Sign Language (ASL), and interpreter services
Check all that apply

- ☐ In-office ASL interpreter
- ☐ In-office medical interpreter
- ☐ Other type of in-office interpreter service, fill in here _____

☐ Race/Ethnicity

^ Race/ethnicity of Provider. Check all that apply:

- ☐ American Indian Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Choose not to share

☐ OTHER

Comments:

PROVIDER RELATIONS REPRESENTATIVE
(Please print)

PROVIDER NAME
(Please print)

SIGNATURE	DATE

^Optional to answer and not required